Medicare Rx Update: January 17, 2006

Addressing implementation issues…

Late last week and through the weekend, Dr. McClellan and the CMS staff continued working with Plans to address issues that have arisen in the implementation of the new Medicare Prescription Drug benefit. On Friday evening, Dr. McClellan sent a letter to partners (http://www.cms.hhs.gov/Partnerships/Downloads/PartnerLetter113.pdf) to speak to some of these issues directly. Also, two additional guidances were sent to Plans urging expedited processes for first fill prescriptions (Strengthening Implementation.pdf) and for application of cost sharing for dual eligibles and other low- income beneficiaries (PartDTransitionCopaysForm 1-13-06.pdf). Both of these guidance documents are intended to reduce the time pharmacists have to spend on the phone to assist patients with plans approvals.

… as enrollment continues to surge

Today, HHS Secretary Mike Leavitt announced that more than 2.6 million Medicare beneficiaries signed up for the new stand-alone coverage in the last 30 days. This number comes on top of the 1 million who enrolled in stand-alone plans in the first 30 days of the initial enrollment period, which began November 15, 2005. "Enrollment in the new Medicare drug benefit is exceeding our expectations and keeping us on track to reach our goal of 28 to 30 million enrollees in the first year," said HHS Secretary Leavitt.

"While most of the 2.6 million new enrollments occurred with the enrollment surge at the end of December, people with Medicare have continued to sign up steadily since then," said Mark B. McClellan, M.D., Ph.D., and Administrator of the Centers for Medicare & Medicaid Services (CMS). The online enrollment center at www.medicare.gov has been processing an average of over 20,000 enrollments a day through the end of last week.

Nearly 24 million seniors and people with disabilities now have prescription drug coverage, including:

- Stand-alone Prescription Drug Plans: about 3.6 million (2.6 million since December 13)
- Medicare/Medicaid: 6.2 million (including 600,000 in Medicare Advantage plans)
- Medicare Advantage: 4.5 million (plus 600,000 Medicare/Medicaid beneficiaries)
- Retiree coverage: About 6.4 million retirees are in employer coverage that is subsidized by the Medicare retiree drug subsidy. Additionally, about 1 million retirees are in employer coverage that incorporates or supplements Medicare prescription drug coverage. Another estimated 500,000 retirees are continuing in coverage that is as good as Medicare's
- TRICARE/ FEHB retirees: 3.1 million.

Continuing to provide systems support...

CMS will continue to send tips for optimizing use of tools and systems. Last week, we disseminated a document that Per-Se Technologies (formerly NDCHealth) provided with an overview of best practices for using the E1 solution (see Eligibility Tips for Pharmacies MDC 011106 Final (2).pdf). As a follow up, CMS has released this simplified overview of the Point of Sale facilitated enrollment solution (see Wellpoint 4 step.doc). This 4 step document should simplify the POS process, which is to be used for dual eligible beneficiaries not enrolled in a plan.

In addition, as announced on the Pharmacy Open Door Forum on January 9, 2006, CMS will begin offering pharmacy-system discussion forums for pharmacists at the local level through

our regional offices. CMS' regional pharmacists will begin this initiative with a series of regional conference calls... which will include users and experts... to illustrate best practices for utilizing these new processes.

Additionally, the American Society for the Automation in Pharmacy (ASAP - http://www.asapnet.org/) and its membership has agreed to work with CMS to help address software-specific implementation issues. ASAP's mission overlays exactly what CMS believes is the full potential of POS enrollment and the E1 transaction; utilizing new computer technology to streamline the pharmacist's efforts and ultimately helping our beneficiaries get the drug coverage they need.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

January 13, 2006

TO: Medicare Part D Plans

SUBJECT: Further Clarification of Formulary Transition Policies

Strengthening Implementation of Formulary Transition Policies

On January 6, CMS issued guidance emphasizing the critical importance of beneficiaries getting their needed first prescriptions filled at the point of sale. Part D sponsors must implement transition policies in a manner that ensures that beneficiaries enrolled in their plan are served promptly and correctly. As previously stated, we expect that Part D sponsors will use sound business and clinical decision making when administering transition supplies and not place undue burden on beneficiaries during the implementation of the benefit. We expect the provision of drugs under your benefit will be such that the enrollee will either have a step edit or prior authorization requirement resolved at the point-of-service, or the enrollee will have access to a temporary supply until such requirements can be met for either formulary or non-formulary drugs. While transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, we must stress that delaying or denying the filling of initial prescriptions for new enrollees at point-of-sale because of prior authorization /edit requirements is not consistent with the intent of CMS' transition policy.

In light of the importance of these transition policies, we are issuing this further guidance requiring that Part D sponsor implementation efforts be strengthened by ensuring that a process is in place that meets or exceeds the steps described below:

Expedited Process for First Fill Prescriptions

- Part D sponsors must establish an expedited process for pharmacists to obtain authorization to override any edits that would apply in the absence of their transition policies.
- Part D sponsors must provide for customer service representatives on pharmacy help lines who have the authority to make or obtain quick decisions on the application of transition policies that are compliant with CMS guidance. This process must also provide for expedited communication of decisions to pharmacists and permit pharmacists to fill prescriptions for covered drugs on a timely basis.
- Upon approval, the customer service representatives must have the capability to operationalize the decision through the claims processing system in real-time to permit the pharmacy to electronically submit the claim and have it accepted.

We understand that some Part D sponsors have implemented their transition processes by providing an override code electronically and others are applying transition policies electronically without the use of an override code. These are also permissible strategies. Your rapid implementation of processes that are efficient for both the pharmacists and the beneficiaries will be extremely helpful in serving your members.

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January 13, 2006

TO: Medicare Part D Plans

SUBJECT: Expedited Processes for Application of Cost Sharing for Dually Eligible and Other Low-Income Beneficiaries

CMS is engaged in intensive efforts to provide all Part D plans with accurate information regarding the correct cost sharing levels for dually eligible and other low-income beneficiaries. As this action continues on an expedited basis, CMS is requiring that Part D plans enhance their interim processes for ensuring that these beneficiaries are not charged standard cost sharing amounts. Part D plans must take immediate steps to ensure that at least one of the following procedures is being effectively implemented when the pharmacy can identify the beneficiary's Part D plan and is seeking confirmation of the beneficiary's low-income subsidy status based upon such information as a Medicaid card, evidence that the prescription was previously filled by the Medicaid program, a CMS letter notifying the beneficiary of auto-assignment, a Social Security Administration letter notifying the beneficiary of eligibility for a low-income subsidy or other similar documentation:

- Expedited Process for Low-income Cost Sharing Approval

  + Part D plans must establish special units that are accessible through plan pharmacy help lines. Calls must be triaged to these special units via either an interactive voice response (IVR) system or customer service representatives (CSR).
  + Customer service representatives in these special units must have the authority to approve application of cost sharing at a level of no more than $2 for generic drugs and $5 for brand name drugs. If sufficient information is available approval should be provided for other cost sharing levels, as appropriate (i.e., 0 cost sharing for beneficiaries in long-term care facilities).
  + Upon approval, the customer service representatives must have the capability to operationalize the decision through the claims processing system in real-time to permit the pharmacy to electronically submit the claim and have it accepted.

- Application of low-income cost sharing and subsequent processing of claims

  + Part D plans must notify pharmacies through such means as interactive voice response systems and faxes that the pharmacy may apply low-income cost sharing at the $2/$5 level for beneficiaries presenting

documentation, such as that described above and hold the claim for resubmission when the beneficiary's correct low-income status has been entered into the claims processing system. Requirements for pharmacies to submit claims within specified time frames (i.e., 14 days) will be temporarily suspended for claims for dually eligible beneficiaries and those presenting documentation of other low-income status.

+ Pharmacies may contact the CMS pharmacy helpline to receive confirmation of the beneficiary's low-income status.
+ For each such inquiry, CMS will send to the Part D plan's secure mailbox confirmation of the beneficiary's low-income status to assist the Part D plan in expediting entry of this information into plan records and permit the earliest possible resubmission of the claim by the pharmacy for approval.
+ In the event of application of low-income cost sharing to a beneficiary who is later determined ineligible for this cost sharing, the Part D plan should establish a process for obtaining the correct cost sharing amount from the beneficiary.

POS Facilitated Enrollment Process:

1. **Request Customer's Part D plan ID card.** Alternatively, individuals may have a plan enrollment "acknowledgement letter" that should contain the BIN, PCN, GROUP, and Member ID information. In addition, even if the individual has no proof of enrollment, their plan's billing information may be available through the new E1 query. If none of these sources of information are available, and the customer is dually eligible for Medicare and Medicaid, the POS Facilitated Enrollment process will still allow you to fill the dual's prescription.
2. **Submit an E1 transaction to the TrOOP Facilitator**. This ensures that the member has not already been assigned to a PDP. If you are not sure how to submit an E1-transaction, please contact your software vendor. If the E1 transaction returns a valid BIN/PCN, indicating the member has been enrolled with a PDP or MA-PD, you may NOT submit the claim under the POS Facilitated Enrollment.
3. **Identify a "Dual Eligible" Member.** The first step is to request the member's Medicare and Medicaid Identification cards. If the member cannot provide clear evidence of enrollment in both programs, the claim should **NOT** be processed under the POS Facilitated Enrollment process. Please see below options available to verify a member's dual eligibility.

   To verify Medicaid eligibility: In addition to the existing state resources, such as IVR systems, you can use the following as verification of Medicaid eligibility:

   - Medicaid ID Card
   - Recent history of Medicaid billing in the pharmacy patient profile.
   - Copy of current Medicaid award letter.

   To verify Medicare eligibility:

   - Submit an expanded E1 query to determine A, B or AB eligibility
   - Request to see a Medicare card; or
   - Request to see a Medicare Summary Notice (MSN); or
   - Call the dedicated Medicare pharmacy eligibility line at 1-866-835-7595.
4. **Bill the POS Contractor.** Please note that there is no need to call WellPoint to confirm enrollment, as no enrollment preexists the claim submission. Please also note that there are no edits for Non-Formulary Drugs, or for Prior Authorization or Step Therapy. However, drugs excluded from Medicare or Part D coverage will not be paid for.

   Make sure you have first submitted an E1 query and ruled out evidence of enrollment in a Part D plan, then enter the claim into your claims system in accordance with the WellPoint (Anthem) payer sheet available at: http://www.anthem.com/jsp/antiphona/apm/nav/ilink_pop_native.do?content_id=PW_A081085. Below is a partial copy of the Payer Sheet specifically for the POS Facilitated Enrollment business segment, highlighting required fields unique to this business. It is important that you carefully review the payer sheet and submit claims in the required format. Please work directly with your software vendor in setting this program up in your system. **Please note, it is critical that we receive both the Medicaid ID number and**

Medicare (HICN) ID number to validate the members "dual eligible" status. Submission of claims without both the Medicaid and the Medicare ID numbers will be considered invalid.

Option 1: For systems that support Cardholder ID and Patient ID fields

Transaction Header Segment: Mandatory in all cases

Field #	*NCPDP Field Name*	*Value*	M/R/RW	Comment
1Ø1-A1	BIN Number	61Ø575	M	
1Ø2-A2	Version/Release Number	51	M	Version 5.1
1Ø3-A3	Transaction Code	B1, B3	M	Billing Transaction
1Ø4-A4	Processor Control Number	**CMSDUALØ1**	M	
1Ø9-A9	Transaction Count	1, 2, 3, 4	M	
2Ø2-B2	Service Provider ID Qualifier	Ø7	M	NCPDP Provider ID
2Ø1-B1	Service Provider ID	NCPDP Provider ID	M	Previously known as NABP Number
4Ø1-D1	Date of Service		M	Format CCYYMMDD
11Ø-AK	Software Vendor/Certification ID		M	Send spaces

Patient Segment: Required

Field	*NCPDP Field Name*	*Value*	M/R/RW	*Comment*
111-AM	Segment Identification	Ø1	M	Patient Segment
331-CX	**Patient ID Qualifier**	**99**	R	**99 - Other** **Values of Ø1, Ø2 and Ø3 are not supported.**
332-CY	**Patient ID**		R	**Submit Medicaid number (up to 14 bytes) when using Patient ID Qualifier (331-CX) = 99**
3Ø4-C4	**Date of Birth**		**R**	**Format CCYYMMDD**
3Ø5-C5	**Patient Gender Code**	**1, 2**	**R**	
31Ø-CA	**Patient First Name**		**R**	
311-CB	**Patient Last Name**		**R**	
322-CM	**Patient Street Address**		**R**	
323-CN	**Patient City Address**		**R**	
324-CO	**Patient State / Province Address**		**R**	
325-CP	**Patient Zip / Postal Zone**		**R**	
326-CQ	**Patient Phone Number**		**R**	**Format AAAEEENNNN**
3Ø7-C7	**Patient Location**	**1, 3, 5**	**R**	**Required When Billing for Patient in a Long-Term Care Setting:** **3 – Nursing Home** **5 – Rest Home** **Required When Billing for HIT:** **1- Home**

Insurance Segment: Mandatory

Field #	*NCPDP Field Name*	*Value*	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	**Cardholder ID**		**M**	**Submit Health Insurance Claim Number (HICN)**
3Ø6-C6	Patient Relationship Code		R	

If you experience problems with the submission requirements described above, you can use option 2 until your software vendor can support Option 1. **Please note, it is critical that we receive both the Medicaid ID number and Medicare (HICN) ID number to validate the members "dual eligible" status.**

Option 2: For systems that do not currently support 2 Member ID numbers:

- BIN: 610575 (Anthem Prescription Management, LLC)
- PCN: CMSDUAL02 (instead of CMSDUAL01 as noted above)
- Medicaid ID number in field 301 C1 Group ID (instead of the Patient ID 332-CY and Patient ID Qualifier 331-CX)
- Patient Segment Required fields as listed above are still required, this includes date of birth, first and last name, full address, phone number and patient location code.
- Medicare (HICN) ID number in field 302 C2 Cardholder ID

Member Coverage:

- Days Supply: Limited to 14 days (This will allow for an appropriate opportunity for members to be enrolled with a PDP)

For Further Assistance:

- Pharmacy Help Desk : (800) 662-0210 – Please note, IVR options enhanced for POS Facilitated claims

  Monday – Friday, 8:30 a.m. – 12:00 a.m. ET

  Saturday & Sunday, 9 a.m. – 7 p.m. ET